

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15394

State File No.

District No. 270

Primary Registration District No. 5909

Registrar's No. 3512

PLACE OF DEATH:

County

City or town

Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

(Specify whether

In this community

3. (a) PRINT
FULL NAME3. (b) If veteran,
name war3. (c) Social Security
No.

4. Sex

5. Color or
race6. (a) Single, widowed, married,
divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive years

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a) BURIAL

(b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4-18-1944

(b) Jesse M. Marky

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write "RURAL")

(d) Street No.

(If rural, give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Month

Day

year

hour

minute

M.

21. I hereby certify that I attended the deceased from

that I last saw him alive on

Immediate cause of death

Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

3. Signature

(M.D. or other)

Date signed

4-44 79

MAY 8

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

....., Registered Apprentice No.
working under my personal supervision.

Signed

Walter A. Hawber

Licensed Embalmer No.

2002

P.O. Address

Kennett m

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

*** If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. 35

Registration District No. 270 Primary Registration District No. 5909

1. PLACE OF DEATH

(a) County Pemiscot
(b) City or town "Rural" Little Prairie Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 35 yrs. (Specify whether
in this community years, months or days)

3. (a) PRINT
FULL NAME

3. (b) If veteran,
name war.

3. (c) Social Security
No.

4. Sex m

5. Color or
race w

6. (a) Single, widowed, married,
divorced m

6. (b) Name of husband or wife.

6. (c) Age of husband or wife if
alive 35 yrs

7. Birth date of deceased.

(Month) (Day) (Year)

8. AGE:

Years 63 Months 2 Days 2 Unless than one day min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal)

(b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar)

(b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
year 1944 hour 1 minute 2 M.

21. I hereby certify that I attended the deceased from 1944 to 1944,
that I last saw him alive on Jan 14, 1944,
and that death occurred on the date and hour stated above.
Immediate cause of death Heart Duration

Due to
Due to

Other conditions
(Include pregnancy within 5 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work? (c) Means of injury

23. Signature (M, D. or other)
Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

15394